

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155173	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2014
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR - MARION	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N BRADNER AVE MARION, IN 46952
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/30/14</p> <p>Facility Number: 000089 Provider Number: 155173 AIM Number: 100287760</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Miller's Merry Manor - Marion was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</p>	K010000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010029 SS=E	<p>capacity of 176 and had a census of 115 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a garage used for the storage of lawn equipment and maintenance supplies.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the</p>	K010029	K 029 It is the policy of Miller's Merry Manor to ensure corridor	07/25/2014			

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	<p>facility failed to ensure the corridor door to 1 of 1 kitchens and 1 of 2 North 2 hall soiled linen storage rooms, both hazardous areas, were self closing and latch into the door frame. This deficient practice could affect residents in 2 of 13 smoke compartments.</p> <p>Findings include:</p> <p>a. Based on an observation with the Maintenance Director on 06/30/14 at 2:05 p.m., the corridor door entering the kitchen dish machine room from the main dining room lacked a self closing device. The main dining room was open to the corridor therefore the kitchen door was in a corridor wall. Based on an interview with the Maintenance Director at the time of observation, a section of the corridor wall was removed during a recent renovation project leaving the door entering the dish machine room in a corridor wall.</p> <p>b. Based on an observation with the Maintenance Director on 06/30/14 at 12:55 p.m., the corridor door to the soiled linen room across from resident room 185 did self close but it failed to latch into the door frame. Based on an interview with the Maintenance Director at the time of observation, the door was catching on the threshold and was prevented from closing completely.</p>		<p>door to kitchen and soiled linen storage rooms, hazardous areas, are self closing and latch into the door frame. Maintenance installed a door closer to the kitchen door and made the necessary corrective action the same day the surveyor identified this. Maintenance also corrected the N2 soiled utility room door, which had a door closer already installed. Maintenance sanded down the bottom of the door so that it would close completely. Maintenance already had a monthly check of proper door closure and at that time the N2 soiled utility room door was rubbing bottom threshold due to swelling of the concrete slab. All residents had the potential to be affected by this practice. Maintenance will continue to check all doors on a monthly basis to make sure all doors that lead to hazardous areas are self closing and latch when closed. This has been an ongoing Quality assurance procedure that is reviewed monthly. The maintenance department will check all doors per quality assurance policy on a monthly basis and if any problems are identified they will be corrected and reported at the Quality Assurance meeting that meets monthly. The maintenance director will use the facility layout map as the audit tool (Exhibit A). Systematic changes will be completed by July 25th 2014</p>				

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K010050 SS=C	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to include the fire drill location and type of fire for 12 of the last 12 calendar months. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill" documentation with the Maintenance Director on 06/30/14 at 10:10 a.m., the fire drill documentation did not include the location of the fire and the type of fire simulated. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K010050	<p>K 050</p> <p>It is the policy of Miller's Merry Manor to include the fire drill location and type of simulated fire on our written documentation for fire drills. The facility does run fire drills at unexpected times under varying conditions and at least quarterly on each shift. When the fire drills are ran, different location in the building are used. The enunciator panel shows location of simulated fire and which alarm type was triggered (Smoke detector, pull station, sprinkler, air handler duct detector).</p> <p>Maintenance and Administrator reviewed currently fire drill form and added two sections. Location of simulated fire and type of simulated fire were added to</p>	07/25/2014			

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically</p>	K010147	<p>current fire drill form. (Exhibit B).</p> <p>All residents and staff had the potential to be affected by not having type of simulated fire or simulated fire location documented on current fire drill form.</p> <p>Measures put into place was a revision of the current fire drill form with two added sections being location of simulated fire and type of simulated fire.</p> <p>Corrective actions include updated fire drill form and will be part of the monthly QA process which is reviewed monthly. Any identified areas of concern will be corrected and reported at the Quality Assurance meeting that meets monthly.</p> <p>Systemic changes will be completed by July 25th 2014.</p> <p>K 147 It is the policy of Miller's Merry Manor to ensure flexible cords are not used as a substitute for fixed wiring to provide power equipment with high current draw in non resident areas or in resident care areas. Maintenance Director unplugged both the microwave and the small</p>	07/25/2014	

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	<p>permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a patient care area but could affect facility staff in the nursing office.</p> <p>Findings include:</p> <p>Based on observations with Maintenance Director on 06/30/14 at 11:30 a.m., a coffee pot, refrigerator and microwave were plugged into an extension cord power strip in the Nursing office. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>refrigerator from the surge protector in the nursing office. The coffee pot was not connected into either wall or surge protector as it was unplugged. Both microwave and refrigerator was plugged directly into the wall and the surge protector was removed from the nursing office. The nursing staff personnel had the potential to be affected by the deficient practice. The maintenance director will continue to audit all resident areas and all non resident areas in the building to ensure all high draw equipment is not plugged into surge protectors. This audit is currently being completed monthly and will continue to be completed monthly. The maintenance director will complete weekly audits of all non resident areas and resident areas of the facility weekly for a total of 4 weeks and then monthly thereafter. This weekly audit will also be part of the Quality Assurance meeting that meets monthly. Any and all areas of concern identified during the audit will be corrected immediately and then reviewed at the monthly QA meeting. Maintenance department will use the facility layout map as an audit tool (Exhibit A). Systemic changes will be completed by July 25th 2014.</p>		